

EXHIBIT 11



Medical Coverage Policy

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Coverage Policy Number 0266

Treatment of Gender Dysphoria

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INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment and have discretion in making individual coverage determinations. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview

This Coverage Policy addresses treatment of gender dysphoria. Gender dysphoria is defined as discomfort or distress that is caused by a discrepancy between a person's gender identity and the person's assigned sex at birth (World Professional Association for Transgender Health, [WPATH], 2012).

Coverage Policy

Coverage for treatment of gender dysphoria varies across plans. Coverage of drugs for hormonal therapy, as well as whether the drug is covered as a medical or a pharmacy benefit, varies across plans. Refer to the customer's benefit plan document for coverage details. In addition, coverage for treatment of gender dysphoria, including gender reassignment surgery and related services may be governed by state and/or federal mandates.¹

Unless otherwise specified in a benefit plan, the following conditions of coverage apply for treatment of gender dysphoria and/or gender reassignment surgery and related procedures, including all applicable benefit limitations, precertification, or other medical necessity criteria.

Medically necessary treatment for an individual with gender dysphoria may include ANY of the following services, when services are available in the benefit plan:

- Behavioral health services, including but not limited to, counseling for gender dysphoria and related psychiatric conditions (e.g., anxiety, depression)
- Hormonal therapy, including but not limited to androgens, anti-androgens, GnRH analogues*, estrogens, and progestins (Prior authorization requirements may apply).
 **Note:* If use in adolescents, individual should have reached Tanner stage 2 of puberty prior to receiving GnRH agonist therapy.
- Laboratory testing to monitor prescribed hormonal therapy
- Age-related, gender-specific services, including but not limited to preventive health, as appropriate to the individual's biological anatomy (e.g., cancer screening [e.g., cervical, breast, prostate]; treatment of a prostate medical condition)
- Gender reassignment and related surgery (see below).

Gender Reassignment Surgery

Gender reassignment surgery is considered medically necessary treatment of gender dysphoria when the individual is age 18 years or older and when the following criteria are met.

Note: For New York regulated benefit plans (e.g., insured): case-by-case review by a medical director for individuals under the age of 18 years of age will be given.

- **For reconstructive chest surgery (i.e., initial mastectomy, breast augmentation):** one letter of support from a qualified mental health professional

NOTE: The Women's Health and Cancer Rights Act (WHCRA), 29 U.S. Code § 1185b requires coverage of certain post-mastectomy services related to breast reconstruction and treatment of physical complications from mastectomy including nipple-areola reconstruction.

- **For hysterectomy, salpingo-oophorectomy, orchiectomy:**

- documentation of at least 12 months of continuous hormonal sex reassignment therapy, AND recommendation for sex reassignment surgery (i.e., genital surgery) by two qualified mental health professionals with written documentation submitted to the physician performing the genital surgery. If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both [for example, if practicing within the same clinic] are required.

¹ New York regulated benefit plans do not include exclusions or plan language that limit coverage.

- **For reconstructive genital surgery:**
 - documentation of at least 12 months of continuous hormonal sex reassignment therapy, AND
 - recommendation for sex reassignment surgery (i.e., genital surgery) by two qualified mental health professionals with written documentation submitted to the physician performing the genital surgery (If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both [for example, if practicing within the same clinic] are required AND
 - documentation the individual has lived for at least 12 continuous months in a gender role that is congruent with their gender identity

Table 1: Gender Reassignment Surgery: Covered Under Standard Benefit Plan Language

The procedures listed below are considered medically necessary under standard benefit plan language when the above listed criteria for gender reassignment surgery have been met, unless specifically excluded in the benefit plan language.

Procedure	CPT / HCPCS codes (This list may not be all inclusive)
Female to Male reconstructive genital surgery:	
Vaginectomy**/colpectomy	55980
Vulvectomy	57110
Metoidioplasty	56625
Phalloplasty	58999
Electrolysis of donor site tissue to be used for phalloplasty	58999
Penile prosthesis (noninflatable / inflatable), including surgical correction of malfunctioning pump, cylinders, or reservoir	17380 54400, 54401, 54405, C1813, C2622
Urethroplasty /urethromeatoplasty	53430, 53450
Hysterectomy and salpingo-oophorectomy	58150, 58260, 58262, 58291, 58552, 58554, 58571, 58573, 58661
Scrotoplasty	55175, 55180
Insertion of testicular prosthesis	54660
Replacement of tissue expander with permanent prosthesis	11970
testicular insertion	11960, 11970, 11971, 54660
Testicular expanders, including replacement with prosthesis, testicular prosthesis	
Female to Male reconstructive chest surgery:	
Initial mastectomy	19303
Nipple-areola reconstruction (related to mastectomy or post mastectomy reconstruction)	19350*
Breast reduction	19318
Pectoral implants	L8600, 17999
Male to Female reconstructive genital surgery:	
Vaginoplasty**, (e.g. construction of vagina with/without graft, colovaginoplasty)	57291, 57292, 57335
Electrolysis of donor site tissue to be used to line the vaginal canal for vaginoplasty	17380 54125
Penectomy	56620, 56805
Vulvoplasty, (e.g., labiaplasty, clitoroplasty, penile skin inversion)	56800
Repair of introitus	44145, 55899

Coloproctostomy Orchiectomy	54520, 54690
Male to Female reconstructive chest surgery:	
Initial breast reconstruction including augmentation with implants	15771-15772 (when specific to breast), 19325, 19340, 19342, C1789

***Note:** CPT 19318 (breast reduction) includes the work necessary to reposition and reshape the nipple and areola. Therefore, CPT 19350 (nipple and areola reconstruction) is considered integral to CPT 19318. Thus, these two codes cannot be billed together for “mastectomy” for the purpose of gender reassignment. However, 19350 would be covered if requested along with 19303 as per the federal mandate.

****Note:** For individuals considering hysterectomy/salpingo-oophorectomy, orchiectomy, vaginectomy or vaginoplasty procedures a total of 12 months continuous hormonal sex reassignment therapy is required.

Table 2: Gender Reassignment Surgery: Other Procedures

The procedures listed below are considered not medically necessary under standard benefit plan language. However, some benefit plans may expressly cover some or all of the procedures listed below for gender reassignment surgery.

Note: For New York regulated benefit plans (e.g., insured): The procedures listed below will be further reviewed on a case-by-case basis by a medical director with particular consideration given to whether the proposed procedure(s) advance an individual's ability to properly present and function in the identified gender role.

Facial Feminization/Masculinization Procedures	CPT/HCPCS Code
Blepharoplasty	15820, 15821, 15822, 15823
Brow lift	67900
Cheek/malar implants	17999
Chin/nose implants, chin recontouring	21210, 21270, 30400, 30410, 30420, 30430 30435, 30450
Collagen injections	11950, 11951, 11952, 11954
Face lift	15824, 15825, 15826, 15828, 15829
Forehead reduction and contouring	21137
Facial bone reduction (osteoplasty)	21209
Hair removal/hair transplantation	15775, 15776, 17380
Jaw reduction, contouring, augmentation	21120, 21121, 21122, 21123, 21125, 21127
Laryngoplasty	31599
Lip lift and lip filling	40799
Rhinoplasty	21210, 21270, 30400, 30410, 30420, 30430, 30435, 30450
Skin resurfacing (e.g., dermabrasion, chemical peels)	15780, 15781, 15782, 15783, 15786, 15787, 15788, 15789, 15792, 15793
Thyroid reduction chondroplasty	31750
Neck tightening	15825
Electrolysis, other than when performed pre-vaginoplasty as outlined above	17380
Removal of redundant skin when performed as part of facial reconstruction	15830, 15832, 15833, 15834, 15835, 15836 15837, 15838, 15839
Suction assisted lipoplasty, lipofilling, and/or liposuction	15830, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839, 15876, 15877, 15878, 15879
Voice therapy/voice lessons	92507
Voice modification surgery	31599, 31899

General Background

The causes of gender dysphoria and the developmental factors associated with them are not well-understood. Treatment of individuals with gender dysphoria varies, with some treatments involving a change in gender expression or body modification. The term “transsexual” refers to an individual whose gender identity is not congruent with their genetic and/or assigned sex and usually seeks hormone replacement therapy (HRT) and possibly gender-affirmation surgery to feminize or masculinize the body and who may live full-time in the transgender role. Transsexualism is a form of gender dysphoria. Other differential diagnoses include, but are not limited to, partial or temporary disorders as seen in adolescent crisis, transvestitism, refusal to accept a homosexual orientation, psychotic misjudgments of gender identity and severe personality disorders (Becker, et al., 1998). Individuals that are transsexual, transgender, or gender nonconforming (i.e., gender identity differs from the cultural norm) may experience gender dysphoria.

Treatment of gender dysphoria is unique to each individual and may or may not involve body modification. Some individuals require only psychotherapy, some require a change in gender roles/expression, and others require hormone therapy and/or surgery to facilitate a gender transition.

Behavioral Health Services

Licensing requirements and scope of practice vary by state for healthcare professionals. The recommended minimum credentials for a mental health professional to be qualified to evaluate or treat adult individuals with gender dysphoria has been defined in the literature. There is some consensus that in addition to general licensing requirements, a minimum of a Master's or more advanced degree from an accredited institution, an ability to recognize and diagnose coexisting mental health concerns, and an ability to distinguish such conditions from gender dysphoria is required.

Mental health professionals play a strong role in working with individuals with gender dysphoria as they need to diagnose the gender disorder and any co-morbid psychiatric conditions accurately, counsel the individual regarding treatment options, and provide psychotherapy (as needed) and assess eligibility and readiness for hormone and surgical therapy. For children and adolescents, the mental health professional should also be trained in child and adolescent developmental psychopathology.

Once the individual is evaluated, the mental health professional provides documentation and formal recommendations to medical and surgical specialists. Documentation for hormonal and/or surgery should be comprehensive and include the extent to which eligibility criteria have been met (i.e., confirmed gender dysphoria, capacity to make a fully informed decision, age \geq 18 years or age of majority, and other significant medical or behavioral health concerns are well-controlled), in addition to the following:

- individual's general identifying characteristics
- the initial and evolving gender, sexual and psychiatric diagnoses
- details regarding the type and duration of psychotherapy or evaluation the individual received
- the mental health professional's rationale for hormone therapy or surgery
- the degree to which the individual has followed recommended medical management and likelihood of continued compliance
- whether or not the mental health professional is a part of a gender team

Psychiatric care may need to continue for several years after gender reassignment surgery, as major psychological adjustments may continue to be necessary. Other providers of care may include a family physician or internist, endocrinologist, urologist, plastic surgeon, general surgeon and gynecologist. The overall success of the surgery is highly dependent on psychological adjustment and continued support.

After diagnosis, the therapeutic approach is individualized but generally includes three elements: sex hormone therapy of the identified gender, real life experience in the desired role, and surgery to change the genitalia and other sex characteristics.

Hormonal Therapy

For both adults and adolescents, hormonal treatment for gender dysphoria must be administered and monitored by a qualified healthcare practitioner as therapy requires ongoing medical management, including physical

examination and laboratory evaluation studies to manage dosage, side effects, etc. Lifelong maintenance is usually required.

Adults: Prior to and following gender reassignment surgery, individuals undergo hormone replacement therapy, unless medically contraindicated. Biological males are treated with estrogens and anti-androgens to increase breast size, redistribute body fat, soften skin, decrease body hair, and decrease testicular size and erections. Biological females are treated with androgens such as testosterone to deepen voice, increase muscle and bone mass, decrease breast size, increase clitoris size, and increase facial and body hair. In both sexes hormone replacement therapy (HRT) may be effective in reducing the adverse psychologic impact of gender dysphoria. Hormone therapy is usually initiated upon referral from a qualified mental health professional or a health professional competent in behavioral health and gender dysphoria treatment specifically. Twelve months of continuous hormone therapy (gender appropriate) is required prior to hysterectomy and salpingo-oophorectomy and orchectomy.

Adolescents: For some adolescents the onset of puberty may worsen gender dysphoria. For these individuals puberty-suppressing hormones (e.g., GnRH analogues) may be provided to individuals who have reached at least Tanner stage 2 of sexual development (Hembree, et al., 2009; World Professional Association for Transgender health [WPATH], 2012). Consistent with adult hormone therapy, treatment of adolescents involves a multidisciplinary team, however when treating an adolescent a pediatric endocrinologist should be included as a part of the team. Pre-pubertal hormone suppression differs from hormone therapy used in adults and may not be without consequence; some pharmaceutical agents may cause negative physical side effects (e.g., height, bone growth).

Gender Reassignment Surgery

The term "gender reassignment surgery," also known as sexual reassignment surgery, gender confirming surgery or gender affirmation surgery, may be part of a treatment plan for gender dysphoria. The terms may be used to refer to either the reconstruction of male or female genitalia specifically, or the reshaping by any surgical procedure of a male body into a body with female appearance, or vice versa in order for an individual to function socially in the role to which they identify. Such procedures that tend to display outward appearance generally include facial procedures, chest reconstructive procedures as well as some genital reconstructive procedures (e.g., phalloplasty).

Gender identity disorder does not persist into adolescence in most children (Hembree, et al., 2009). Evidence suggests that 75-80% of prepubertal children do not turn out to be transgender in adolescence (Hembree, et al., 2009). According to WPATH (2007) persistence of gender dysphoria from adolescence into adulthood is much higher. Performing gender reassignment surgery prior to age 18, or the legal age to give consent, is not recommended by professional societies (American College of Obstetricians and Gynecology [ACOG], 2017; WPATH, 2012; American Psychiatric Association (APA), 2012, Endocrine Society, 2009). Gender reassignment surgery is intended to be a permanent change (non-reversible), establishing congruency between an individual's gender identity and physical appearance. Therefore, a careful and accurate diagnosis is essential for treatment and can be made only as part of a long-term diagnostic process involving a multidisciplinary specialty approach that includes an extensive case history; gynecological, endocrine and urological examination; and a clinical psychiatric/psychological examination. Individuals who choose to undergo gender reassignment surgery must be fully informed regarding treatment options with confirmation from the mental health professional that the individual is considered a candidate for surgical treatment.

Twelve months of continuous hormone therapy is required prior to irreversible genital surgery unless medically contraindicated. Contraindications to hormonal therapy include but are not limited to hypercoagulability conditions, known coronary artery disease, liver disease, and venous thromboembolism.

In addition, prior to surgery the individual identified with gender dysphoria must undergo a "real life experience". During this time the individual adopts the new or evolving gender role and lives in that role for at least 12 continuous months as part of the transition pathway. This process assists in confirming the person's desire for gender role change, ability to function in this role long-term, as well as the adequacy of his/her support system. During the real life experience a person would be expected to maintain their baseline functional lifestyle, participate in community activities, and provide an indication that others are aware of the change in gender role. Some individuals may not be able to continuously live in the gender role for which they identify, for example, concerns surrounding one's employment environment may preclude an individual from meeting this requirement.

In such instances the clinician must confirm the individual has had a satisfactory social role change prior to surgery.

Other Associated Surgical Procedures

Services Otherwise Medically Necessary: Age appropriate gender-specific services that would otherwise be considered medically necessary remain medically necessary services for transgender individuals, as appropriate to their biological anatomy. Examples include (but are not limited to):

- for female to male transgender individuals (e.g., who have not undergone a mastectomy, breast cancer screening)
- for male to female transgender individuals who have retained their prostate cancer screening or treatment of a prostate condition.

Reversal of Gender Reassignment: Gender reassignment surgery is considered an irreversible intervention.

Although infrequent, surgery to reverse a partially or fully completed gender reassignment (reversal of surgery to revise secondary sex characteristics), may be necessary as a result of a complication (i.e., infection) or other medical condition necessitating surgical intervention.

Masculinization/Feminization Procedures: Various other surgical procedures may be performed as part of gender reassignment surgery, for example masculinization or feminization procedures. When performed as part of gender reassignment surgery some procedures are performed to assist with improving culturally appropriate male or female appearance characteristics and may be considered not medically necessary. Please refer to the applicable benefit plan document for terms, conditions, and limitations of coverage in addition to the applicable Cigna Medical Coverage Policy for conditions of coverage.

Professional Society/Organization

American College of Obstetricians and Gynecologists (ACOG): ACOG published a Committee Opinion in 2017 for the care of transgender adolescents. Within this document regarding surgical management ACOG notes transgender male patients may undergo phalloplasty when one reaches the age of majority, and a transgender female patient may undergo vaginoplasty when one reaches the age of majority. In addition the authors acknowledge the Endocrine Society guidelines (Hembree, et al., 2009) which state that an individual is at least age 18 years for genital reconstructive surgery (ACOG, 2017).

American Psychiatric Association (APA): In 2012 the APA published a task force report on treatment of gender identity disorder. Within this document, regarding adolescents specifically, the authors state the evidence is inadequate to develop a guideline regarding the timing of sex reassignment surgery. However the task force acknowledges the Endocrine Society guidelines (Hembree, et al., 2009) and that given the irreversible nature of surgery, for adolescents most clinicians advise waiting until the individual has attained the age of legal consent and a degree of independence (APA, 2012).

WPATH Standards of Care: The World Professional Association for Transgender Health (WPATH) promotes standards of health care for individuals through the articulation of "Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People" (WPATH, 2012, Version 7). Although there is no recent update, WPATH standards of care are based on scientific evidence and expert consensus and are commonly utilized as a clinical guide for individuals seeking treatment of gender disorders.

Endocrine Society: In 2009 the Endocrine Society published a clinical practice guideline for endocrine treatment of transsexual persons (Hembree, et al., 2009). As part of this guideline, the endocrine society recommends that transsexual persons consider genital sex reassignment surgery only after both the physician responsible for endocrine transition therapy and the mental health professional find surgery advisable; that surgery be recommended only after completion of at least one year of consistent and compliant hormone treatment; and that the physician responsible for endocrine treatment medically clear the individual for sex reassignment surgery and collaborate with the surgeon regarding hormone use during and after surgery.

Use Outside of the US: Several other countries including the United Kingdom offer treatment options for individuals with gender dysphoria. Treatments are similar to those offered in the United States.

Medicare Coverage Determinations

	Contractor	Policy Name/Number	Revision Effective Date
NCD	National	No National Coverage Determination	
LCD		No Local Coverage Determination	

Note: Please review the current Medicare Policy for the most up-to-date information.

Coding/Billing Information

Note: 1) This list of codes may not be all-inclusive.

2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Table 1: Gender Reassignment Surgery: Covered Under Standard Benefit Plan Language

Intersex Surgery: Female to Male

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
55980	Intersex surgery, female to male
11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion
11970	Replacement of tissue expander with permanent implant
11971	Removal of tissue expander without insertion of implant
17380†	Electrolysis epilation, each 30 minutes
17999††	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
19303	Mastectomy, simple, complete
19318	Breast reduction
19350†††	Nipple/areola reconstruction
53430	Urethroplasty, reconstruction of female urethra
53450	Urethromateoplasty, with mucosal advancement
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401	Insertion of penile prosthesis; inflatable (self-contained)
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir
54660	Insertion of testicular prosthesis (separate procedure)
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
56625	Vulvectomy simple; complete
57110	Vaginectomy, complete removal of vaginal wall
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)
58260	Vaginal hysterectomy, for uterus 250 g or less
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58999††††	Unlisted procedure, female genital system (nonobstetrical)

[†]**Note:** Considered medically necessary when performed as electrolysis of donor site tissue to be used for phalloplasty.

^{††}**Note:** Considered medically necessary when used to represent pectoral implants.

^{†††}**Note:** Considered medically necessary when performed as part of a mastectomy or breast reconstruction procedure following a mastectomy. Considered integral and/or not covered when performed with reduction mammoplasty.

^{††††}**Note:** Considered medically necessary when used to report metoidioplasty with phalloplasty.

HCPCS Codes	Description
C1813	Prosthesis, penile, inflatable
C2622	Prosthesis, penile, non-inflatable
L8600	Implantable breast prosthesis, silicone or equal

Intersex Surgery: Male to Female

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
55970	Intersex surgery; male to female
15771†	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate
15772†	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)
17380††	Electrolysis epilation, each 30 minutes
19325	Breast augmentation with implant
19340	Insertion of breast implant on same day of mastectomy (ie, immediate)
19342	Insertion or replacement of breast implant on separate day from mastectomy
44145	Colectomy, partial; with coloproctostomy (low pelvic anastomosis)
54125	Amputation of penis; complete
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54690	Laparoscopy, surgical; orchietomy
55899†††	Unlisted procedure, male genital system
56620	Vulvectomy simple; partial
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
57291	Construction of artificial vagina; without graft
57292	Construction of artificial vagina; with graft
57335	Vaginoplasty for intersex state

HCPCS Codes	Description
C1789	Prosthesis, breast (implantable)

[†]**Note:** Considered medically necessary when used to report liposuction techniques specific to breast augmentation.

^{††}**Note:** Considered medically necessary when performed as electrolysis of donor site tissue to be used to line the vaginal canal for vaginoplasty.

†††Note: Considered medically necessary when used to report coloproctostomy.

ICD-10-CM Diagnosis Codes	Description
F64.0	Transsexualism
F64.1	Dual role transvestism
F64.2	Gender identity disorder of childhood
F64.8	Other gender identity disorders
F64.9	Gender identity disorder, unspecified
Z87.890	Personal history of sex reassignment

Table 2: Gender Reassignment Surgery: Other Procedures

Generally considered not medically necessary when performed as a component of gender reassignment even when coverage for gender reassignment surgery exists, unless subject to a coverage mandate or specifically listed as available in the applicable benefit plan document.

Note: For New York regulated benefit plans (e.g., insured): Subject to case by case review by a medical director.

CPT®* Codes	Description
11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less
11951	Subcutaneous injection of filling material (eg, collagen); 1.1 to 5.0 cc
11952	Subcutaneous injection of filling material (eg, collagen); 5.1 to 10.0 cc
11954	Subcutaneous injection of filling material (eg, collagen); over 10.0 cc
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15783	Dermabrasion; superficial, any site (eg, tattoo removal)
15786	Abrasion; single lesion (eg, keratosis, scar)
15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
15824	Rhytidectomy, forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy; cheek, chin, and neck
15829	Rhytidectomy; superficial musculopaponeurotic system (SMAS) flap
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand

CPT® Codes	Description
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
17380	Electrolysis epilation, each 30 minutes
17999†	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
19324	Mammoplasty, augmentation; without prosthetic implant (Code deleted 12/31/2020)
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)
21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21125	Augmentation, mandibular body or angle; prosthetic material
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
21137	Reduction forehead; contouring only
21209	Osteoplasty, facial bones; reduction
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21270	Malar augmentation, prosthetic material
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
31599††	Unlisted procedure, larynx
31750	Tracheoplasty; cervical
31899†††	Unlisted procedure, trachea, bronchi
40799††††	Unlisted procedure, lips
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual

†Note: Generally not medically necessary when used to report cheek and malar implants or fat transfers performed in conjunction with gender reassignment surgery, even when coverage for gender reassignment surgery exists.

††Note: Generally not medically necessary when used to report laryngoplasty and/or voice modification surgery performed in conjunction with gender reassignment surgery, even when coverage for gender reassignment surgery exists.

†††Note: Generally not medically necessary when used to report voice modification surgery performed in conjunction with gender reassignment surgery, even when coverage for gender reassignment surgery exists.

††††Note: Generally not medically necessary when used to report lip reduction/enhancement performed in conjunction with gender reassignment surgery, even when coverage for gender reassignment surgery exists.

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